EXHIBIT B

University of Washington Medical Centers
Family and Medical Leave Certification of Health Care Provider for Personal Serious Health Condition

To Employee: Complete the upper right corner of this page and arrange for your health care provider to complete the remainder of the form. **Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it.** Return it to the appropriate office indicated in the space to the right. Contact this office if you believe that you will not be able to return the completed form within the specified time period.

To Employee – Please complete the following information:

Name: MARTHILDE BRZYCKI
Dept.: Harborview Stroke Center EID: 853103278
Employee Phone: 206-457-9669
Employee email: MJeanty@uw.edu

☒ Harborview Medical Center
Human Resources Operations Office
325 Ninth Avenue
Box 359715
Seattle, WA 98104-2499
Phone: (206) 744-9220
Fax: (206) 744-9955
Or, send scan to: HMCFMLA@uw.edu

☐ UW Medical Center
Human Resources Operations Office
1959 NE Pacific
Room BB150, Box 356054
Seattle, WA 98195
Phone: (206) 598-6116
Fax: (206) 598-4610
Or, send scan to: UWMCFMLA@uw.edu

Medical Facts – TO BE COMPLETED BY HEALTH CARE PROVIDER

Our employee is requesting leave from work and/or a modified work schedule under the FMLA for a health condition. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to our employee's request to take leave or adopt a modified work schedule.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Describe the medical facts related to the condition(s) that require our employee to be off work and/or to work a reduced or intermittent work schedule (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy):

Pt is having increased anxiety w/ panic type disorder. She needs 4 weeks off of work to reduce stress. The anxiety is affecting her sleep, blood pressure, and quality of daily life.

Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☐ No ☐

If yes, dates of admission: N/A

Date(s) you treated patient for this condition: 12/07/16 and 11/14/16

Will your patient need to have treatment visits at least twice per year due to the condition? Yes ☑ No ☐

Was medication, other than over-the-counter medication, prescribed? Yes ☐ No ☑

Was your patient referred to other health care provider(s) for evaluation or treatment? Yes ☐ No ☑

If yes, describe the nature and expected duration of the treatments:

Pt is seeing a counselor.

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For Pregnancy-Related Incapacity

Expected date of delivery: _____

Planned C-Section? Yes ☐ No ☐

Expected dates of your patient's physical incapacity due to pregnancy and delivery (not parental leave):

From (date): _____ to (date): _____

Rev 3/2016

EXHIBIT 6
SCHURINGA
11/5/2019
Buell Realtime Reporting
206-287-9066

Need for Leave or Work Schedule Adjustment

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "indeterminate" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act.

Continuous Leave:

Will your patient be incapacitated for a single, continuous period of time including time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for the period of incapacity:

From (date): 12/7/16 **to (date):** 1/10/17

Intermittent Leave:

Will the condition(s) cause episodic flare-ups that prevent your patient from performing his/her job functions? Yes ☐ No ☐

If yes, please explain:

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 time per 3 months, 2 days per episode)

Frequency: _____ time(s) per _____ week(s) -or- _____ month(s)

AND

Duration: _____ hours or _____ day(s) per episode

From (date): _____ **to (date):** _____

Appointments:

Are follow-up and/or periodic treatment appointments medically-necessary for your patient? Yes ☑ No ☐

If yes, describe the anticipated treatment schedule and any treatment recovery period(s):

pt to see counselor & continue relaxation techniques

Will there be a need for planned medical appointments and/or absences? Yes ☐ No ☑

Frequency: _____ time(s) per _____ week(s) -or- _____ month(s)

AND

Duration: _____ hours or _____ day(s) per episode

From (date): _____ **to (date):** _____

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Reduced/Modified Work Schedule:

Will your patient require a reduction in or modification of the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐

If yes, describe the reduced or modified work schedule that you believe is medically necessary:

This work schedule needs to be in place **from (date):** _____ **to (date):** _____

Health Care Provider Information (please complete or attach business card)

Name (please print) Elizabeth Schuringa, ARNP Specialty ARNP

Business Address _____ Phone _____ Fax _____

Health Care Provider Signature (required) ESchuringa Date 12/8/16

Elizabeth Schuringa, ARNP
Overlake Medical Clinic
Downtown Bellevue
400 108th Ave NE, Suite 100
Bellevue, WA 98004
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